On Villous Growths and the Common Affections of the Rectum.

T. Bryant.

PRESENTED BY

The Author.

ON VILLOUS GROWTHS AND THE COMMON AFFECTIONS OF THE RECTUM.

(Illustrated.)

BY

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PREFACE.

THESE papers have been reprinted from the 'Lancet' with the object of drawing attention to the subject of Villous Growths and Perforating Ulcers of the Rectum, as I have reason to believe that these affections are not so widely recognised as they should be; but I also hope that the illustrations, mostly copied from the admirable drawings of the late Mr. P. Y. Gowlland, may make the letterpress of the common affections of the anus and lower bowel both helpful and acceptable to the junior members of the profession.

THOMAS BRYANT.

65, *Grosvenor Street, W.*

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ON VILLOUS GROWTHS AND THE COMMON AFFECTIONS OF THE RECTUM.

General Remarks.

By the death of a valued surgical friend and enthusiastic artist, Mr. P. Y. Gowlland, who, after being a surgeon to the London Hospital, found his life's work in a speciality, I have become through his widow the distributor of a large number of drawings of anal and rectal diseases which are not only of great artistic and surgical value but at the same time of rarity, for the nature of the speciality does not readily lend itself to pictorial representation, and it was only by an enthusiastic surgeon with artistic tastes that such a subject could have been adequately illustrated. The best of the late Mr. Gowlland's drawings are now in the possession of the Royal College of Surgeons of England, where they will always be open to the inspection of the Members of the College; but many are still in my hands to be disposed of according to my discretion. The possession of these drawings has therefore induced me at the present time to write the following notes on anal and rectal diseases, and to anticipate the intention I had formed of adding, at some future date, a chapter upon these important affections to those I have already published under the heading of 'Gleanings from Surgical Practice,'* for, with my late friend's drawings to illustrate the subject, my remarks may be made more useful.

And first of all it must be asserted, and most dogmatically so, that anal and rectal surgery is not as a rule well treated by the bulk of the medical practitioners of this country, for by the public most anal troubles are diagnosed as "piles," and the practitioner, when consulted, is too apt to accept the diagnosis of his patient

* 'Lancet,' 1895–96.

and to treat him or her without making any local examination by which alone a correct diagnosis of the case can be made, and a line of treatment laid down which may be expected to be successful. Under such circumstances cases are too often allowed to drift, and although trivial cases may get well by such a process some become serious and the bulk of them pass into a chronic condition, entailing much unnecessary suffering and often serious consequences. It need hardly be added that the practitioner, in so acting, is not doing his duty or his best for his patient. When, therefore, a patient experiences so much anal or rectal distress as to induce him or her to seek advice it should be the invariable rule of the practitioner consulted to make a local examination, and this should be of such a character as to afford sufficient information to allow of the adoption of a rational treatment from which benefit can be anticipated.

How to Examine Patient.

An examination need be neither a painful nor a humiliating proceeding; it may always be conducted decently and should be so conducted. The position in which I prefer to place a patient is on a bed or couch on the left side with the thighs flexed. In this position, with the patient's buttocks well separated, a good view of the anus and its surroundings can be obtained, and much knowledge can be acquired by mere inspection. If the skin about the anus and anal fold is healthy, pruritus as a local affection may be dismissed with other external local troubles; if the skin be inflamed or irritated local rectal trouble should be suspected. If the anus is patulous some prolapse of the rectum may be present, and it will be at once seen whether the prolapsed tissue is simply mucous membrane, hæmorrhoidal, or polypus structure. If there is redundant skin about the anus and it is loose the antecedent prolapse of some tissue is suggested, and if the redundant skin is œdematous or otherwise infiltrated the recent prolapse of hæmorrhoidal or other structure or some lower rectal disease is rendered probable. If fæces or discharge flow from the patient's anus the possibility of rectal stricture or rectal ulceration should be raised. If the anus be drawn tight and seems to be the apex of a cone the presence of an anal fissure or ulcer should be suspected, and if this condition is induced or increased on the surgeon attempting

to separate the parts, and if, moreover, at the dorsal or perineal end of the anus a skin papilla is present, the suspicion of fissure would be confirmed. If any appearances of local inflammation are present they would be seen, as would any true external pile. All these points would be made out by mere anal inspection and careful painless examination; to learn more the introduction of the finger or speculum into the rectum may be required, and this should be undertaken either at the examination, which has been described, or at a later period. As a rule the whole examination should be made at once, although its postponement should invariably be followed when an anal fissure or ulcer has been found, or is suspected to be present, since the introduction of a finger or of a speculum past the external sphincter muscle would, under these circumstances, excite intense pain, consequently all further examination should be undertaken with the patient anæsthetised.

Pruritus Ani.

This affection should always be regarded as a symptom of some local rectal trouble, and not as a disease *per se*, although it is not possible in some few cases to find out readily its precise cause. It is well known to be present in cases of ascarides, and it may be in every variety of rectal trouble, including external and internal piles, polypi, ulceration of the anus or rectum of every kind, and anal abscesses. When none of these causes exist some irritating rectal secretion, with or without a congested pelvic condition, may be suspected, particularly in women with any uterine affection. Stimulating articles of diet and beer and spirits may also cause it, but what I now wish to impress upon the practitioner is that pruritus ani is commonly a symptom of rectal trouble and must be so dealt with. Recently I attended a woman who had suffered from anal pruritus for 15 years unattended by other symptoms. She had taken much advice, but had never been examined. On a careful investigation I found a sessile polypus, the size of a haricot bean, situated just within, but not protruding beyond, the sphincter. This I removed with an early and complete cure of her trouble.

Anal and Rectal Abscess.

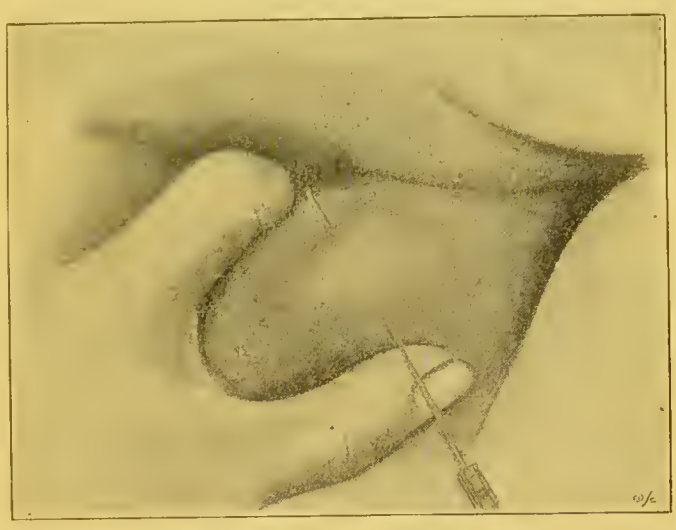
What has struck me most in the treatment of these cases is the undeniable fact that the majority of such abscesses have been

allowed to take their natural course and have not been dealt with as abscesses in other parts would probably have been—that is, by an early incision. By the use of poultices, and the necessary delay occasioned by their employment, many cases, which would have been regarded as trifling, have drifted into a serious condition, and many a local abscess which, by a timely incision, might have been speedily cured has passed either into an extensive diffused abscess requiring many incisions, or has degenerated into a condition of fistula with multiple openings, for the cure of which multiple incisions have been demanded. For it should never be forgotten that abscesses which form in the loose connective tissue about the rectum and ischio-rectal fossa readily burrow in all directions. Under these circumstances it should be a rule of practice to open them as soon as possible, and this rule is as applicable to the small anal abscess, with the view of saving pain, as to the larger ischio-rectal abscess, to save burrowing. Any abscess in these regions, if opened early, may be expected to heal without becoming a fistula, whereas if allowed to drift it will not only with certainty become a fistula, but probably a complicated one with many sinuses. A superficial anal abscess may be opened as any other in a superficial position; a deep-seated ischio-rectal abscess wants some care. With the patient placed on his side at the edge of a bed and anæsthetised, the surgeon's finger, well and thickly lubricated with some lard ointment, should be introduced into his rectum and pressed sufficiently far into the bowel so as to reach above or behind the abscess cavity, the object of this movement being to enable the surgeon to press the abscess cavity well forwards towards the perineum, and with a straight bistoury to make a free incision into it (*vide* Fig. 1). The cavity should then be irrigated with iodine water or some other antiseptic lotion and a piece of iodoform gauze introduced between the edges of the external wound for drainage purposes. There is no necessity for any plugging of the abscess cavity, for the hope of the surgeon is that the walls of the cavity, when cleansed as they should have been, will fall together and unite as speedily as possible; any filling of the abscess cavity with dressing would be enough to prevent this desirable result taking place, and at the same time would help to bring about the formation of a fistula.

A small acute abscess near the anus will produce in some cases severe pain in the part and also in the groin with which it is

associated by lymphatics, and the nearer it is to the anal orifice the greater will be the pain. The sooner this abscess is therefore relieved by an incision the sooner will relief be given. In deep-seated abscesses the same practice is called for, and when burrowing has taken place the surgeon should follow up the track of burrowing with great care. Some of the worst examples of ischio-rectal abscesses are those due to ulceration of the rectum caused by the presence of a foreign body, such as the bone of a

FIG. 1.



Method of opening an ischio-rectal abscess.

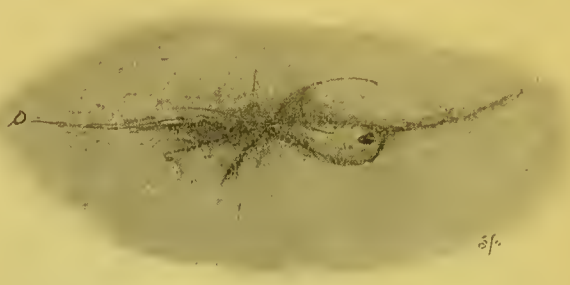
fish or otherwise, and most of such cases are really fæcal abscesses due to extravasation.

PERINEAL AND RECTAL FISTULA.

When an abscess has failed to heal and has passed into the condition of an anal or of what I prefer to designate a "rectal fistula," a careful local examination should be carried out, although not before a full history of the case has been obtained. The surgeon should, with the patient placed on either his right or left side—the side selected being the one upon which the external orifice of the fistula is placed—begin his examination by carefully feeling the external parts for hardness, and when such is found to exist, its extent and direction should be noted, and particularly with reference to its relations with the external

opening or openings of the fistula, for where any hardness is present it is probable that there either is or has been some inflammatory action, and under these circumstances that there may be present some branch sinus, which, although not suggested by the external orifices of the fistula, has to be traced and laid open.

Fig. 2.



Sketch of a case of fistula in a man aged 43 years.

The question of the existence or position of the internal orifice of the fistula into the bowel has next to be considered, and in the cases in which the patient states he has satisfied himself that

Fig. 3.

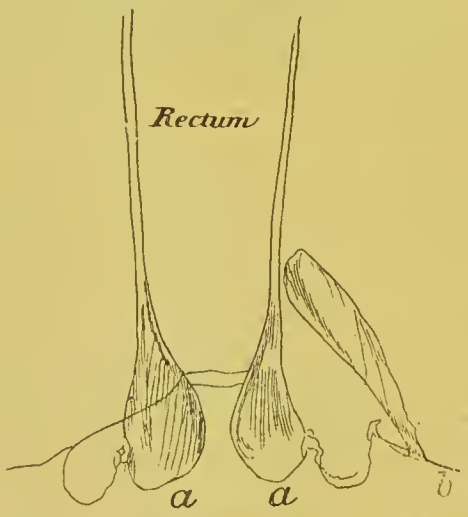


Diagram representing a case of prolapsed hæmorrhoids (*a*) (*a*) with blind external fistula (*b*).

wind passes through the external opening of the fistula, the deduction is clear that an internal opening exists, although the precise seat of the orifice must still be obscure. To find the orifice

of communication a carefully conducted local examination is essential. As a rule of practice it is generally well for the surgeon to pass his probe-pointed director through the external fistulous opening, before he passes his finger into the bowel, for in passing his finger, however gentle the surgeon may be, some spasm of the anal sphincter must occur, and in that way a difficulty is made to the passage of the instrument by the muscle throwing the sinus out of a right line. No force should be used in passing the probe, and should an obstruction be met with it would be well to remove the probe and give it a bend with the concavity upwards, the bend tilting the end of the probe upwards against the bowel.

FIG. 3A.

Diagram representing a case of blind internal fistula. (*a*) Seat of external abscess where opened.

When the probe has passed its supposed course the surgeon should then introduce his finger and thus determine the point he wished to elucidate. He has also, if there are many external sinuses, to make out whether each one has its own internal opening or whether there may be only one common opening, the more usual condition. He has likewise to satisfy himself that the sinus which communicates with the bowel ends at the internal opening or whether it passes up beyond, and, if so, how far. He should also so examine the soft parts around the external opening or openings as to be sure that they are not undermined or the seat of other lateral sinuses, for in the treatment of a fistula every

sinus should be found, and, as a rule, laid open, branching sinuses, or what have been described as ⊤ sinuses, always requiring this treatment.

The internal orifice of the fistula should always be made out, and with care it can generally be detected. It feels with the surgeon's finger in the rectum, when recent, like a depression in the walls of the bowel, and, when of long standing, more or less indurated. In exceptional cases the walls of the rectum may be extensively ulcerated, and under such circumstances the internal orifice of a rectal fistula will be difficult to recognise by the sense

FIG. 3B.

Diagram representing a case of fistula, with one external opening (*a*) and two internal openings.

of touch. At times the internal opening is so large as to admit the tip of the finger; under these conditions previous ulceration has doubtless been present, and has been the cause of the fistula or fistulæ, for where a large abscess has been the result of rectal ulceration, several external openings about the anus are usually present. Injecting the external fistula with milk or some coloured injection will often be a help in detecting the presence or position of an internal opening. The accompanying diagrams taken from Mr. Gowland's drawings will illustrate most of these points and variations of fistulæ.

As a rule the division of a rectal fistula when well performed is a successful measure, and where failure follows it is as often due to the presence of constitutional causes as of local. The former

FIG. 3C.

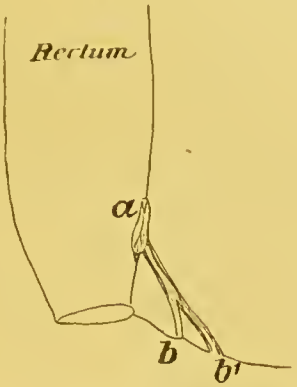


Diagram representing a case of fistula, with one internal opening (*a*) and two external openings (*b*), (*b'*). The patient, a man, was 37 years of age.

may be difficult to overcome. The latter are mostly in the surgeon's power to control. Thus failure at times follows an operation when the surgeon has not found the internal aperture of the fistula, and has thus left a sinus extending above the internal

FIG. 3D.

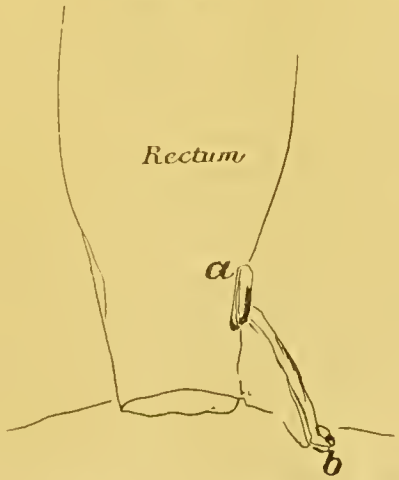


Diagram representing a case of fistula, with internal opening (*a*) and external opening (*b*).

opening, which for a successful result should have been laid open. Failure likewise may follow any operative measure when any external sinus has been overlooked or not laid open, whether

branch sinus or otherwise. It should also be pointed out that failure at times follows operation when the surgeon has been satisfied by dividing the sphincter and laying open a single sinus, but has omitted to cut away overlapping edges of skin or scraping away old sinus tissue, particularly in tuberculous subjects. Failure also is sure to follow where the fistula is the secondary effects of some rectal disease, such as extensive ulceration or any stricture of the bowel. In treating a blind internal fistula it is as a rule expedient to open first the abscess situated at the lower or perineal end of the sinus and subsequently to divide the external sphincter with the sinus channel.

FIG. 3E.

Diagram representing a case of fistula with three internal and external openings. The shaded area was the seat of ulceration. The patient, a boy, was 19 years of age.

In dressing a fistula after operation there is no need, after the first dressing, for any daily plugging of the wounds. Such wounds must, of course, be kept clean, but dressings are only needed to keep the edges of the skin wound from healing too rapidly before the deeper parts have filled up. The careful paring of the overlapping and undermined skin renders this old practice now unnecessary. The bowels should be kept open and the motion soft, not loose—for liquid stools are apt to excoriate, and always give more local pain to wounds about the anus than do the soft and pultaceous motions.

Perforating Ulcers of the Rectum.

That a simple ulcer may start in the rectum and perforate its walls, and so give rise to a fæcal ischio-rectal abscess is a well-recognised fact, but I am not so sure that the profession, as a body, recognise the occurrence of a simple ulcer of the rectum perforating its walls at some higher or lower level, and giving rise to fæcal extravasation with, as a result, septic cellulitis of the perineum, abdominal parietes, gluteal region, and scrotum in the male and external genital organs of the female. I should like also to add to those possibilities a perforation of the bladder in the male and of the vagina in the female subject. I have seen and had under my care examples of all these conditions, and have a few rough notes of some of them, to which I wish to draw attention.

Case 1.—The first case of the kind I saw was in 1858 when acting as surgical registrar to Guy's Hospital, and the patient was one under the care of the late Mr. Hilton. The man, aged 60 years, was admitted into the hospital in May, 1858, with œdema and inflammatory infiltration of the perineum, scrotum, and abdominal parietes as high as the thorax, and all these parts were emphysematous. This condition had commenced in the perineum and scrotum two days previously without any known cause. He had not had any difficulty in micturition, and his urine was clear and urethra healthy, nor so far as he knew was there any bowel trouble. Free incisions were made in every quarter that was involved, when fæcal air escaped and fæcal fluid was washed away. Rapid failure of power, however, set in, and the man died on the fifth day. A necropsy revealed that the urinary passages and organs were healthy and intact, but an ulcer was found in the anterior wall of the rectum, half an inch above the anus, which had perforated its walls and allowed the contents of the bowel to escape into the cellular tissue of the perineum and give rise to the condition described.

Case 2.—In 1875 I was called to see a married woman, aged about 45 years, who when in apparent good health was suddenly seized with pain of a burning nature in her perineum which was rapidly followed by swelling of the external genital organs, and within 24 hours of the right gluteal region. I saw her on the second day and found all those parts swollen and emphysematous, and she was in a high state of fever. Free incisions into these swollen tissues gave vent to fœtid fæcal air and dead tissue, and on making a rectal examination a large opening was found in the rectum on its right and anterior wall. By free irrigation of the tissues, the use of antiseptic lotions in the form of iodine water, and the removal of sloughs, a good recovery was brought about.

Case 3.—In October, 1875, I was asked to see a married woman, aged 30 years, who was pregnant four months, for a sudden swelling of the

external genitals and vagina, of the right thigh and lower part of the abdomen as high as the umbilicus. It had existed about 24 hours, and had come on when she appeared to be in good health. I found all these parts inflamed and swollen and of a dusky hue, also crepitating to the touch, and the patient was very ill. By free incisions, however, into all these œdematous and emphysematous tissues, and the free use of iodine water by irrigation and constitutional treatment, a convalescence was brought about, and she subsequently gave birth to a healthy child. In her case I found high up in the rectum a perforating ulcer which had made its way into the sacral cavity, and hence the trouble.

Case 4.—In 1874 a man, aged 53 years, was admitted into Guy's Hospital under my care who for three years had been passing flatus and, later, fæces with his urine, and for some months flatus and fæces without urine through his urethra. Some urine at the same time used to pass per anum. A rectal examination revealed an ulcer on its anterior wall at the base of the prostate, and as this was supposed to be sufficient to explain his symptoms I made a perineal incision and laid the bladder open into the rectum as in the old operation of recto-vesical lithotomy. This measure gave relief, but the patient gradually sank from kidney disease and some localised pelvic peritonitis. At the necropsy a simple ulcer of the rectum was found which had opened through the prostate into the base of the bladder, and which had been attacked by the operation; but one inch behind this and to the left of the median line was a second ulcer in the rectum of the same simple character, which had perforated its walls, and so on to and through the bladder. The local peritonitis was caused by this latter ulcer. There was no sign of new growth in either the rectum or bladder. The kidneys were much diseased.

The case above briefly quoted is an example of what, I am convinced, is by no means a rare condition, and to which I drew attention in 1872, when I read before the Clinical Society of London the notes of two cases of recto-vesical fistula, due to simple rectal ulceration, treated successfully by left lumbar colotomy. One of these cases was in a man, aged 64 years when he underwent the operation, and who lived in comfort for six years after it, and died from a ruptured heart at the age of 70 years. After death evidence of cicatricial repair of old ulceration was present in the rectum, with a very small fistulous opening between the bladder and rectum, which was still patent, and through which a very little urine during life had passed at times into the rectum, but this had never been a source of trouble. The second case was of a man, aged 49 years, who had been passing fæces and flatus with his urine for three and a half years before I operated in 1870, and who made a good recovery. One year after operation he wrote: "No wind or fæces have passed into the bladder since the operation, although a little urine still

passes into the rectum." In 1884 he wrote: "The operation has been quite successful, as it has added 14 years to my life. I am quite free from pain, and I feel as strong as if nothing was the matter with me. The contents of the bowel all pass through the opening in the loin; nothing passes into the lower bowel except a little water from the bladder." Since these cases occurred I have had others to support the view they illustrate; for example, in 1882 I had a patient, aged 65 years, who died from pleurisy and œdema of the lung, who 12 years before had passed flatus with his urine without any known cause or any other symptom. This he continued to do for some months, when he got well. At the *post-mortem* examination the evidence of old ulceration of the rectum and of the former recto-vesical fistula was very clear, and there was a complete absence of any local organic disease.

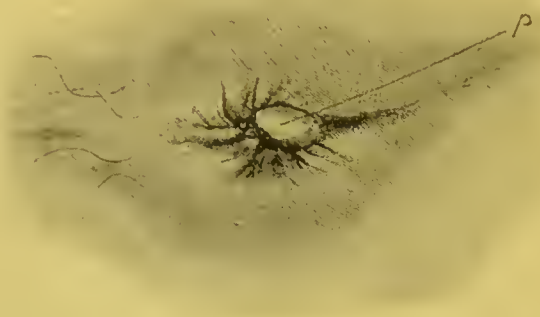
These cases are full of interest, and entirely support the observations I made in 1872, when I reported the two cases of colotomy for recto-vesical fistula, "that ulcerated openings sometimes take place between the bladder and either the large or small intestines, many of which have no connection with stricture of the bowel and even less with cancer."

On Fissure or Painful Ulcer of the Anus.

It might have been thought since the symptoms of this affection are so characteristic that either a mistake in its diagnosis or a chance of its being overlooked were most improbable events, and yet it is true that from some cause or other such cases are too often passed over and allowed to drift. They are either regarded as piles by the patient, and so treated on the patient's diagnosis by the practitioner, or the diagnosis is supposed to be confirmed if, after a superficial external examination, anything like a prolapsed internal or a swollen external pile is seen, or even a small prolapse of the mucous membrane of the bowel, or possibly a papilla-like fold of anal integument situated at either the dorsal or perineal extremity of the anus which is mistaken for a pile. Whereas to detect an ulcer a more careful examination of the part is absolutely essential, together with a greater appreciation of the value of the papilla-like fold of anal integument as a guide to an ulcer, for this fold of anal skin or papilla is one of the most constant and valuable indications of this kind of ulcer, whether associated or not with hæmorrhoidal trouble. To determine the

fact of the existence of this ulcer no painful examination is either necessary or justifiable, for a painless external examination, if rightly made, can at once determine the question. In the drawings which are here copied from my lost friend's original,

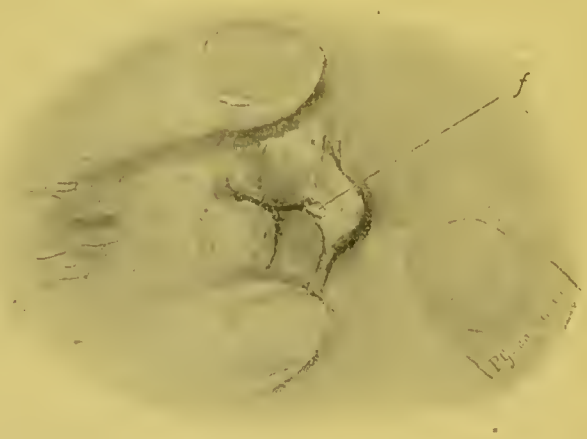
FIG. 4.



Fissure of the anus as seen without the speculum, the characteristic papilla (P) concealing anal ulcer.

the method is well seen, and needs no lengthy description (Figs. 4, 4A, 5, and 5A). With the patient on his side and the thighs

FIG. 4A.

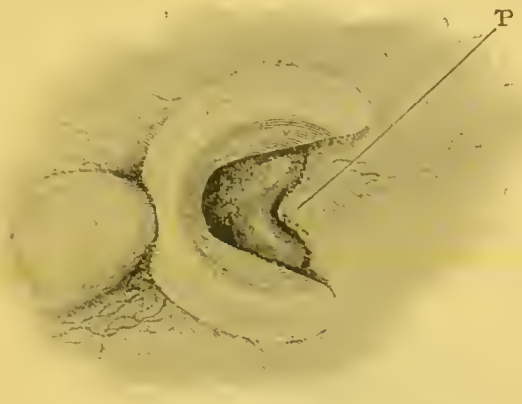


A fissure (*f*) exposed without the use of the speculum.

well flexed, the buttocks are separated, and the surgeon with the thumb and index finger of one hand laterally draws aside the two sides of the anus, and with the finger or thumb of the other hand raises or pulls down the characteristic fold of skin or papilla

beneath which the presence of an ulcer is suspected, when, if it be present, the extremity of the ulcer or the whole ulcer will at once be seen, even if the ulcer exists alone or is found to co-exist

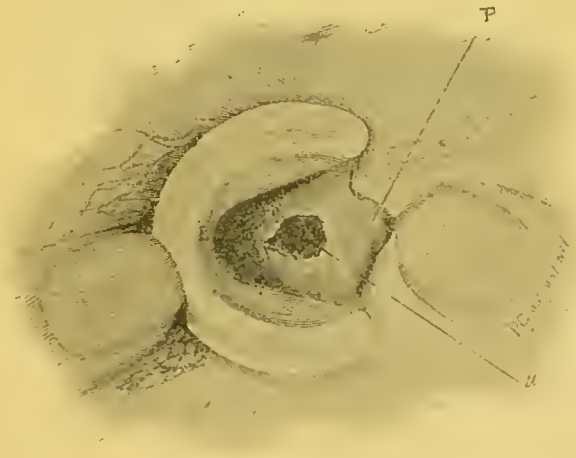
FIG. 5.



Anal ulcer as seen with the speculum. P marks the papilla covering the ulcer.

with external or internal piles, or even with a polypus; for it cannot be too well recognised that cases of piles, prolapse of the rectum, and polypi, when the seat of severe pain, are mostly so

FIG. 5A.



Anal ulcer as seen with the speculum. The papilla (P) has been drawn aside to expose the ulcer (U).

from their being complicated with the painful ulcer; indeed, it is often owing to the grafting of this acute trouble upon an old one that the patient is induced to seek professional advice for his

chronic affection. Should the ulcer be associated with piles or rectal prolapse, the patient will often tell you that since he has had the severe local pains neither the piles nor prolapsed bowel have come down so much as they did formerly, and that he has been able, therefore, to sit down with greater comfort, having been led by these apparent improvements to think that his piles or prolapse had taken a favourable turn; whereas the intelligent surgeon should, in this report of his patient, be led to a different conclusion, and find an explanation of the facts which he may accept from his patient, that the protrusion of the rectal trouble has lessened because the anus has become less patulous from the

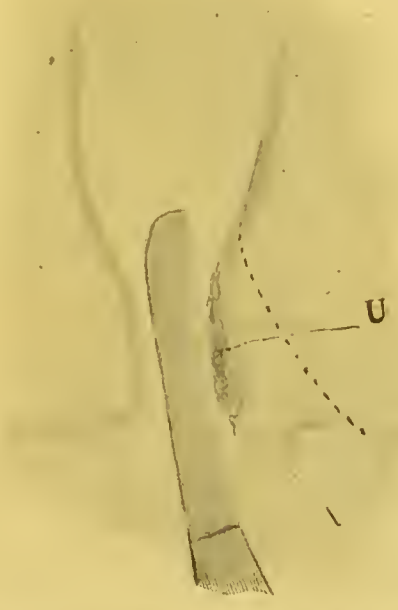
Fig. 6.

A typical anal ulcer as displayed by the speculum.

spasmodic contraction of its sphincter muscle, which is always associated with this anal ulcer, and as a consequence lessens or forbids the prolapse which formerly occurred. Indeed, whenever a patient complains of sudden accession of anal pain in the act of defecation, and the persistence of a burning, cutting pain for a few or many minutes, or even for hours after the act; whenever a patient who has been known to have piles or prolapse suddenly becomes the victim of this intense local pain and, as a consequence, seeks for relief, the presence of this trouble should be suspected, and no treatment ought to be suggested before such a careful local examination as I have described has been carried out.

When this trouble is grafted on to others, and piles, polypus, or prolapsus co-exist, the treatment of the recent affection should be

FIG. 6A.



The division of the ulcer. U marks the seat of the ulcer.

FIG. 6B.

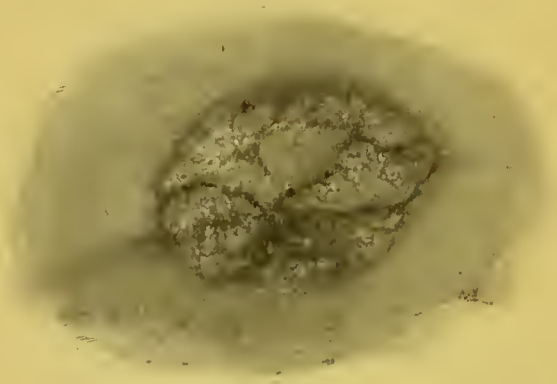
P marks the papilla which covered the ulcer in case illustrated by Figs. 6 and 6A.

included in the treatment of the older trouble, and a cure of both should be secured.

In Mr. Gowlland's drawings are to be seen many examples of anal ulcer associated with piles, prolapse, and polypus. The patient may refuse an examination with the natural dread of serious pain being excited or increased by the introduction of a finger, for he knows too well what torture the passage of a hard motion causes, and that a liquid one is often as bad; but the practitioner can with confidence promise him that no pain shall be caused, for by careful manipulation such as has been described (Figs. 4, 4A) no pain need be or should be occasioned.

When the ulcer is once recognised, its cure is soon brought about, if it be uncomplicated, by a forcible dilatation of the anus

FIG. 7.



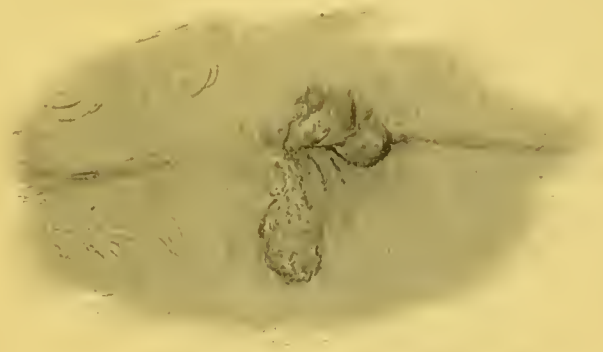
A typical anal wart.

followed by a well-made incision through the whole length of the centre of the ulcer, together with half an inch of the healthy tissue above and below its border (Figs. 6 and 6A), the incision being made to penetrate only through some of the superficial fibres of the sphincter muscle, whereas in slighter cases the forcible dilatation of the sphincter will suffice by itself. If the ulcer has been of long standing, a deeper incision may be necessary than when it is of recent origin, but I have never seen an uncomplicated case of anal ulcer in which the division of the whole sphincter of the anus was required. Figs. 7, 8, 8A, 8B, and 9 illustrate other anal ulcers and growths which must be recognised for diagnostic reasons.

Hæmorrhoids, External and Internal.

In the estimation of the public almost every anal trouble is regarded as hæmorrhoids, and when the practitioner consulted

Fig. 8.

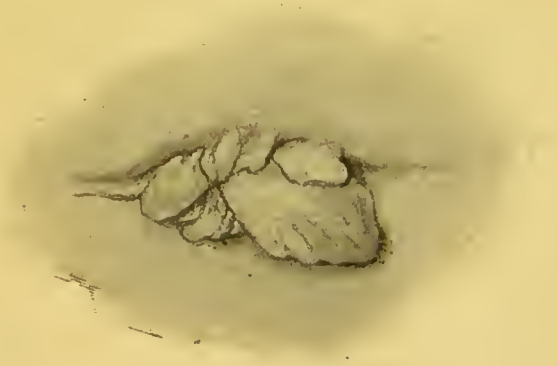


Typical anal condylomata. The patient was a woman aged 21 years.

Fig. 8a.

Typical anal condylomata. The patient was a woman aged 20 years.

Fig. 8b.

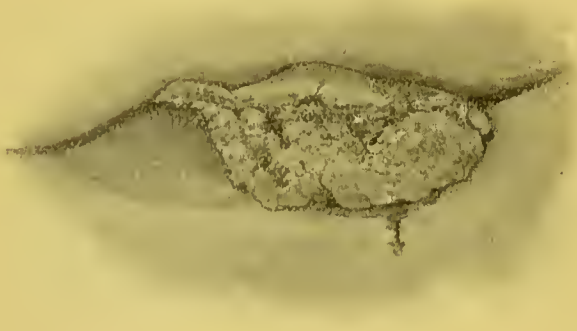


Typical anal condylomata in a male patient.

is satisfied to accept his patient's diagnosis without making a local examination to satisfy himself as to its accuracy, errors

of both diagnosis and treatment must of necessity constantly ensue. It should, consequently, be a rule of practice, whenever a patient complains of supposed hæmorrhoids, for the family medical adviser to ask for a local examination, and, what is more, such should be conceded and carefully carried out before he ventures to prescribe or assumes any responsibility, and certainly before he prescribes the favourite confection of senna and gall ointment. In hospital experience a large number of so-called hæmorrhoids are examples of condylomata the result of syphilis (*vide* Figs. 8, 8A, and 8B), or of anal warts (Fig. 7), but they may be of chancre or of cancerous disease (Fig. 9). In private practice they may be of the same nature, but they may be anything.

FIG. 9.

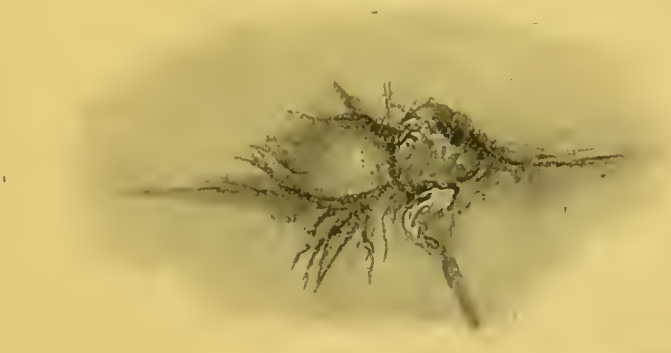


A malignant ulcer of the anus.

A local inspection will reveal much to a surgeon with an educated eye. If the anus and parts about appear to be normal, many possibilities are at once negatived. If loose folds of skin about the anus are visible, the question of the former existence of external hæmorrhoids is naturally raised; if a soft venous swelling is seen, a recent external hæmorrhoid may be diagnosed (Fig. 10); if it be hard, the vein will have become thrombosed; and if it be red and tender, inflamed. If the external anal folds of skin are œdematous or indurated, the surgeon has to decide whether these conditions are due to a syphilitic affection or to some internal rectal disease, and this question can only be decided by an internal rectal examination. If but one indurated or raised skin papilla is present (*vide* Fig. 4), and this is situated at either the dorsal or perineal extremity of the anus, the question of anal ulcer should be at once raised, as has been already pointed out.

Should, however, the surgeon, in making a local inspection, find some prolapse of the mucous membrane of the rectum showing either like the tip of a tongue of mucous membrane (Fig. 11), or as several tips, or as a more or less marked prolapse of one or more masses of mucous tissue with everted and possibly

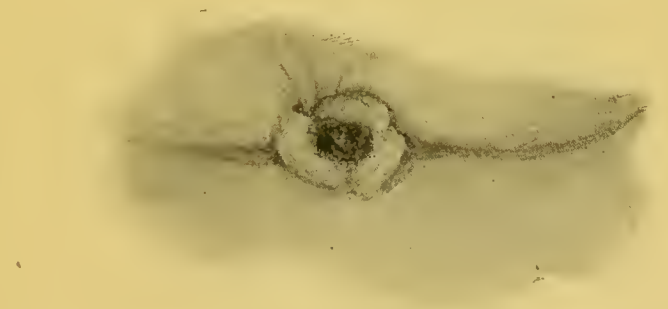
Fig. 10.



Hæmorrhoida vera of three weeks' standing. The patient was a woman aged 54 years.

œdematous anal skin folds (Figs. 11A, 11B), the surgeon has to decide whether the local trouble is one of prolapse of only the mucous membrane of the rectum or prolapse of some true internal hæmorrhoid, or of both tissues together; when bleeding to any

Fig. 11.

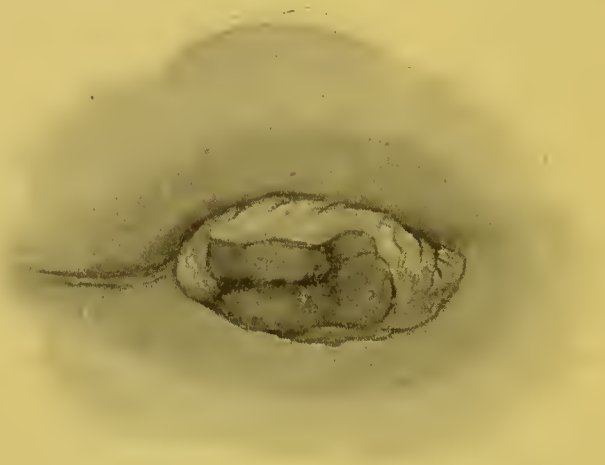


Slight prolapse of the rectum of four years' standing. The patient was a man aged 28 years.

extent complicates the case, the diagnosis is speedily made—for prolapsed mucous membrane rarely bleeds so freely or easily as prolapsed hæmorrhoids—and the venous variety of hæmorrhoid (Fig. 10) is also readily diagnosed from the highly vascular arterial hæmorrhoid. Should only one mass of mucous tissue

project from the anus, the thought of the mass being a polypus should always pass through the surgeon's mind. If the patient be a child, a mucous polypus is the most probable cause, since

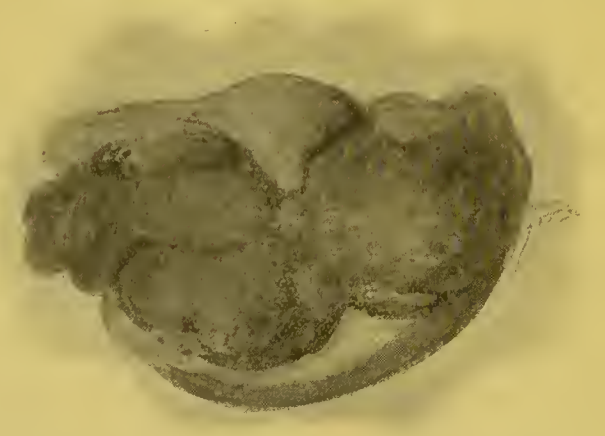
FIG. 11A.



Moderate prolapse of the rectum in a man.

hæmorrhoids in young people are rarely met with; if an adult, some solid fibrous or villous growth is to be expected. But in

FIG. 11B.



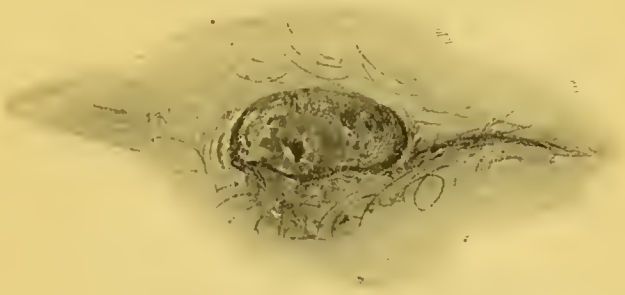
Prolapsed internal hæmorrhoids. The patient was a man aged 36 years.

every example of prolapse of the rectum, whether associated or not with hæmorrhoidal disease, the question of the disease being due to or complicated with the existence of a polypus, single

or multiple, should always be in the mind of the investigating practitioner.

In a popular and clinical point of view hæmorrhoids may be divided into the "bleeding" and "non-bleeding." The bleeding variety is, as a rule, of the internal kind, although if a true external hæmorrhoid ruptures, the varicose vein which forms it may bleed profusely and dangerously (Fig. 12). The internal hæmorrhoid may bleed only when its owner passes a motion, but at times it may do so independently of such an action, and under these circumstances it is certain that some prolapse of the hæmorrhoid exists, although the prolapse may be but slight (Fig. 11A). With respect to prolapse of the hæmorrhoid or hæmorrhoids, all degrees of severity are met with. The hæmorrhoidal masses may vary from one to four or more. The protrusion may only take

FIG. 12.



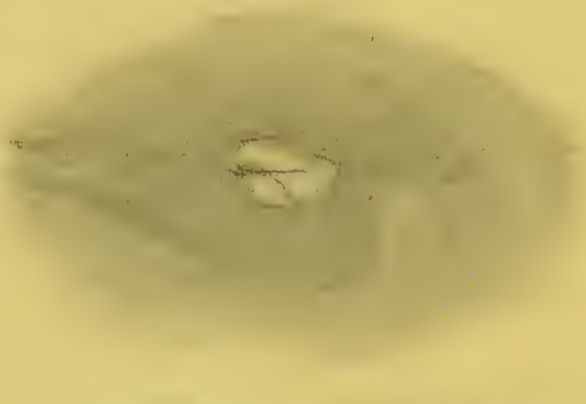
Ruptured external hæmorrhoid. The patient was a man aged 51 years.

place during the act of defecation, or it may recur when coughing, bending forwards, lifting weights, or straining takes place. It may disappear on the patient assuming the horizontal position, to reappear on any standing or sitting posture; or it may be more or less of a constant character, and prone to increase on any exertion.

The amount of possible prolapse in any given case can, however, never be accurately determined before a full enema of warm water or soap and water has been administered to bring the prolapsed hæmorrhoids well into view, and this measure should invariably be taken in every case of prolapse or hæmorrhoids or suspected hæmorrhoids before a definite diagnosis is made or any operation for their cure is decided upon. The enema in bad cases should be as much as a patient can well bear. If the surgeon depends upon

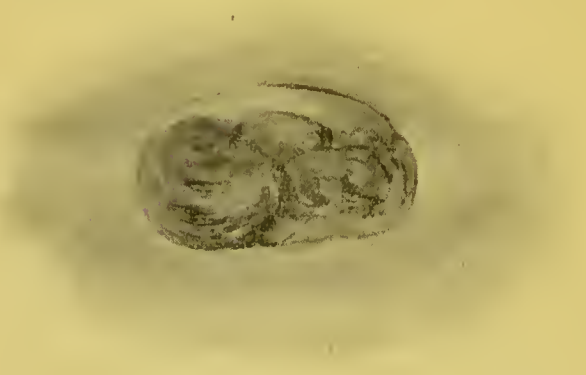
the straining efforts of his patients or upon a small enema he will occasionally only operate upon half the disease. I have seen many cases of failed operations for prolapse and internal hæmorrhoids which I am convinced have been due to a want of proper attention to the practice I am emphasising.

FIG. 13.



After reduction of bowel, or before use of enema.

FIG. 13A.

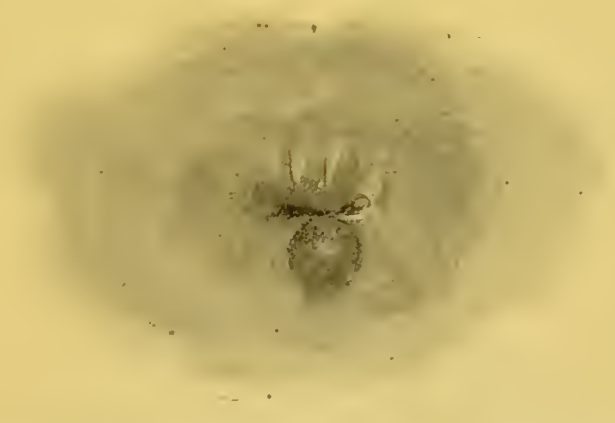


Bowel down after use of large enema. Procidentia recti in a man aged 30 years who had had it from childhood.

Mr. Gowlland's many drawings illustrating the local appearances of bad cases of hæmorrhoids before an enema and after its administration—two of which are reproduced in Figs. 13 and 13A—demonstrate very forcibly his opinion upon the matter with the necessity of every surgeon keeping it in his mind. The

amount of pain that is present with hæmorrhoids, and even with prolapsed hæmorrhoids, is very variable. A small external hæmorrhoid is often far more painful than a large internal one, and partienlarly when the hæmorrhoid has inflamed, the extreme sensibility of the anal integument being the probable explanation of the faet. Internal hæmorrhoids, if they do not protrude far enough to be eaught by the sphineter, or to beeome inflamed or strangulated by the sphineter, may be tolerated by their possessors for very extended periods, and nothing beyond ineonvenienee is eommonly eomplained of. When these beeome the seat of pain I am eonvineed that sueh has been brought about by some small fissure or uleer having been started by either a large motion

Fig. 14.

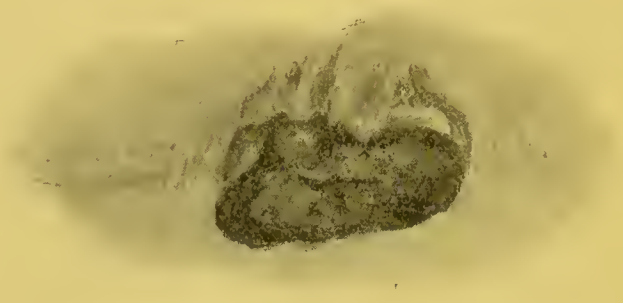


Hæmorrhoida vera and anal fissure. The patient was a man aged 62 years.

eracking the diseased anal tissues or some loeal souree of irritation eausing uleeration, for it is true that the surgeon will usually deteet the presenee of a fissure or uleer in most of the eases of painful hæmorrhoids for whieh he is eonsulted, when the history of the ease will have told him that the existenee of the hæmorrhoids had been reeognised for months or even for years (Fig. 14). Sueh a view of these eases has its practieal bearing, for it is more than probable that it is from the want of loeal eleanliness by washing that these ehronie and eomparatively painless hæmorrhoids have beeome aeute and painful on aeeount of the uleeration which is exeited from the want of due personal attention to this matter. A person with hæmorrhoids should always well wash the parts after defeeation. Besides being the source of hæmorrhage

and of prolapse, hæmorrhoids may inflame, and as a result of inflammation they may ulcerate. An external hæmorrhoid often inflames, and when it does, if it is not actively dealt with, it may become the seat of abscess, and if neglected of fistula.

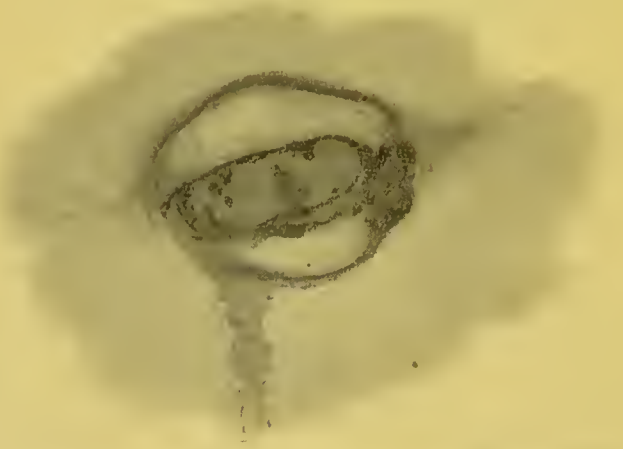
Fig. 15.



Sloughing external hæmorrhoid. The patient was a man aged 65 years.

An internal hæmorrhoid may likewise inflame, and when it does the inflammation is mostly due primarily to its prolapse, and secondarily to some spasmodic action of the external sphincter, this action bringing about the more or less complete strangulation

Fig. 15a.



Sloughing hæmorrhoid after strangulation from prolapse in a man.

of the hæmorrhoid, and the inflammation, ulceration, or sloughing of its substance (Figs. 15, 15a). When an internal hæmorrhoid is thus strangulated it swells rapidly, and soon with the tissues about becomes œdematous and the seat of severe pain ; and if this

condition is not relieved the hæmorrhoid will slough, a natural cure by a painful process being the result.

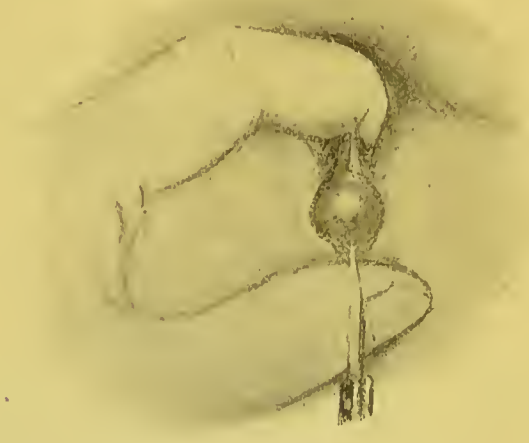
Treatment of Hæmorrhoids.

It is to be regretted that the public as a body are too apt to neglect this trouble and to allow it, whether real or suspected, to drift or run its course and only to seek surgical advice when pain has become a serious symptom or bleeding has become more than an occasional accompaniment. This custom is much to be condemned, for hæmorrhoids as a rule are well amenable to medical and surgical treatment in their early stage, and the cases which now pass into the surgeon's hands for treatment would be far less numerous and severe than they often are, whilst in a large number even of serious cases an operation would not be called for. The public are aware that constipation is a prolific cause of hæmorrhoids, and as a consequence they feel quite competent to treat themselves and so resort to strong medicines, or to the quack nostrums which are so freely advertised and forced upon their notice, or they will consult a druggist, who, because he sells drugs and makes them up, is by some occult process supposed by so doing to have learned the difficult duties of a physician and be competent to advise; or they take the prescription of a friend who had been treated for this affection, or the domestic pill of a wife or relation for whom the pill had been prescribed by some eminent man with good effect, but for some trouble which may probably have differed very widely from his or her own. By these means much harm is done, for although hæmorrhoids are caused and aggravated by constipation the use of powerful purgative medicines, such as most quack pills contain, are in a general way injurious and are not to be recommended when the sufferer's family medical attendant would certainly, with greater safety and propriety, supply an efficient remedy as soon as he has satisfied himself of the nature of the case he has to treat, for it must be repeated that an affection which is often considered by the public to be hæmorrhoids is frequently something far different.

Purgative medicine for hæmorrhoids or for any healthy person ought never to be powerful; where such means are required it is in cases in which the bowel has been brought into bad habits and must be led out of them by dieting and the careful use of medically-prescribed medicines, for I believe that the free use of

quack pills and amateur advice has tended much to the increase of hæmorrhoids. This advice is given with the view of preventing hæmorrhoids and when they are present of relieving them. Much also may be done by dieting. The too free use of brown meats, such as beef and mutton, is to be condemned, particularly by men or women who cannot take much exercise; and even then it is wise to be more free with fish and birds than with beef and mutton. Any adult who takes two liberal meals of brown meat a day is doing his best to generate hæmorrhoids. Well-cooked vegetables are always good. Much potato is not to be recommended, and anything like freedom with alcoholic liquors is to be condemned. I have known people who have had hæmorrhoids,

FIG. 16.



An external hæmorrhoid being laid open.

and some very bad ones, ward off for years, and sometimes for ever, the necessity of a surgical measure for their relief by never taking brown meats and living on fish or birds in moderation, with well-cooked vegetables and fruit, at the same time avoiding alcoholic liquors. If then under these somewhat grave conditions an affection which has grown to be a serious one can be kept in check, surely by the same means adopted at an earlier stage of its formation equal good may be expected. Experience proves that this may be the case.

With respect to the special treatment of external hæmorrhoids it may be said that the loose folds of skin which go by this name

need not, as a rule, be interfered with unless they become the seat of trouble—that is, of fissure between the folds or of ulceration. Should such complications occur the anus should be well stretched and the folds of skin cut off, the lines of incision radiating from the anus and the cut edges of the skin stitched together. Should a varicose vein, as seen in Fig. 10, be the source of trouble, or one ruptured, thrombosed, or inflamed be present it must be treated. If the vein be merely varicose a good clearing out of the bowel by a full dose of castor-oil—say an ounce—will probably be sufficient with a day or so's rest to bring about a cure. If the vein be thrombosed, as seen in Fig. 16, it must be laid open and the clot turned out. Should this measure have been omitted and the thrombosed hæmorrhoid has inflamed and suppurated it must likewise be laid open, otherwise it may become a fistula, the local application of lead and opium lotion helping to complete the cure.

The Treatment of Internal Hæmorrhoids.

When these have become a serious local trouble much may yet be done in the way of their relief as well as in that of cure by following out the suggestions which have just been made under the heading of Preventive Treatment, and when these fail much can also be done by surgical methods. For an internal pile that does not protrude so as to come under the influence of the external sphincter or prolapse beyond it, and only bleeds at long intervals of time and then but little, the preventive treatment I have described ought to be sufficient to retard its growth if not to bring about its cure, and if the patient makes up his mind to follow the treatment out persistently such a hope may be promised and realised. Should the hæmorrhoids, however, protrude so as to come under the influence of the external sphincter this desirable result is not to be expected, and under such circumstances some operation for their cure should be entertained, and particularly if the case be complicated with hæmorrhage. In some early instances the simple dilatation of the sphincter ani—when the patient has been brought under the full influence of an anæsthetic—will be found sufficient to bring about a cure; and as this simple proceeding is one which is always the first a surgeon undertakes when about to perform any operative curative measure upon an internal hæmorrhoid, it is well, when the hæmorrhoidal disease is found to be of recent origin

or very limited, to give it a fair trial. The same line of treatment is likewise applicable to cases in which a small hæmorrhoid is complicated with a fissure or painful ulcer of the anus. When the hæmorrhoid is large or there is more than one, and these are of long standing, this simple dilating procedure cannot alone be expected to bring about a cure, and under such circumstances some additional measures should be undertaken. If the hæmorrhoid be single the application of a silk ligature to its base after its separation from the skin and submucous tissue by scissors is a favourite operation, the base of the hæmorrhoid being transfixed by a needle armed with a double silk ligature, the surgeon being careful, before the ligature is finally tightened, to cut off the distal portion of the strangulated hæmorrhoid to relieve tension. In my own practice I have, however, preferred the removal of all internal hæmorrhoids, whether small or great, by means of the clamp and cautery, the benzene cautery having rendered such a measure more facile. This practice has in my hands been very simple and successful, and I am unable to give any other results than good. I am not prepared to say that these results are better than those secured by the methods which other surgeons advocate and practise, but I must say that they are certainly as good.

Where a single hæmorrhoid exists or several small ones are present the mere ignipuncture by the thermo-cautery in one, two, or more places after anal dilatation has been accomplished, often acts very beneficially. The operation by crushing I have entirely given up—it was a mere passing fashion. The treatment of internal hæmorrhoids by the subcutaneous injection of diluted carbolic acid is only in exceptional cases a satisfactory measure on account of its uncertainty and its comparative tediousness. It is only applicable to internal hæmorrhoids, and, as a rule, one hæmorrhoid should be treated at a time. It consists of the injection into the centre of a hæmorrhoid of five or six drops of a solution composed of equal parts of carbolic acid and glycerine by means of a hypodermic syringe. The acid should turn the hæmorrhoid white, and in favourable cases the hæmorrhoid should then wither without pain or sloughing. In other cases the hæmorrhoid sloughs. Its advantages are that it can be employed in patients who require operative measures and fear the cure by operation yet hating the disease, and who are indifferent to the

expenditure of time in being cured. The practice cannot, however, be strongly recommended on account of its uncertainty.

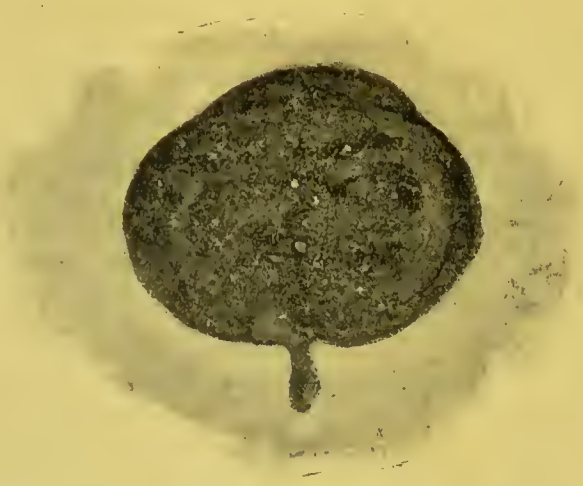
Where internal hæmorrhoids have prolapsed and become extruded from the anus so as to be nipped or possibly strangulated by the external sphincter, the surgeon has a painful and difficult case to deal with. If the strangulation be recent, the hæmorrhoid of medium size, and the parts are swollen from œdema and inflamed, any attempt to reduce the prolapsed hæmorrhoid will without doubt fail, even though the surgeon may succeed in putting it for a time out of sight, for the hæmorrhoid is certain to come down again within a brief period. Such cases had better be left alone and a lotion of lead and opium applied to the part, unless the surgeon is prepared to attempt a curative measure, and with the patient under an anæsthetic to stretch the anus and reduce the hæmorrhoid, with the hope that the inflammatory condition caused by the constriction of the hæmorrhoid by the sphincter will speedily subside and the hæmorrhoid itself subsequently wither and disappear. I have employed this treatment on many such occasions as these and been well pleased with the result. I am sure it is better than any expectant method. If when this measure has been employed the rectum is found to be loaded, it should be emptied by means of a full enema, and when the operation is completed a morphia suppository should be introduced and belladonna ointment applied to the anus. If the strangulated parts have already become gangrenous or have sloughed (Fig. 15A) the treatment I have alluded to is inapplicable. In such cases the parts must be kept clean and treated locally as required.

Prolapsus Recti.

Prolapse of the rectum to variable degrees of severity is so frequently associated with hæmorrhoids that one affection is often mistaken for the other, and where the prolapse is not severe it is as amenable as hæmorrhoids to local treatment. When the case is so mixed the presence of the hæmorrhoids is the probable cause of the prolapse, and from this connection of the two affections it is always to be remembered that however troublesome prolapse of the rectum may be it is rarely an affection by itself, but is the result of some definite cause which has to be made out (Fig. 17). Hæmorrhoids and polypus are the more common causes of this

affection, but rectal growths of all kinds—polypoid or sessile, bowel irritation of all degrees, ulceration and other conditions of the bowel, bladder, penis, or similar parts which induce straining, may bring it about. It is likewise often met with where from some cause or other the sphincter ani has lost its power, as in cases of rectal fistula requiring serious or extensive operations or from the atony of the aged. In the treatment of prolapse the removal of its cause is the one principle of practice to be followed, although when the local affection is so severe as to require treatment it should be dealt with much in the same way as has been described for the treatment of prolapse associated with hæmorrhoids. In

FIG. 17.



Procidentia recti of five years' standing associated with bleeding at times, which could be returned by pressure. The patient was a woman aged 27 years.

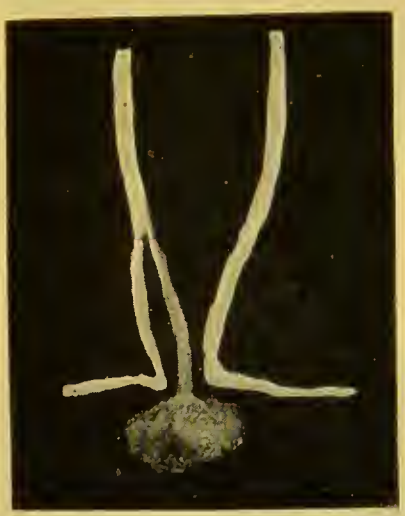
cases in which there does not seem to be any necessity for the removal of the prolapsed and redundant mucous membrane and yet the prolapse is extreme, the linear cauterisation of the prolapsed bowel with the thermo-cautery is a very valuable method of treatment, care being observed not to destroy more than the mucous membrane of the prolapsed bowel before it is returned to its normal position; when removal of the redundant and prolapsed mucous membrane is called for it should be carried out by taking away vertical folds of the tissue, each fold alternating with healthy tissue. In acute prolapse or procidentia there is at times some difficulty in maintaining the reduction of the bowel

after it has been affected; in such cases I have found the use of an anal plug for a few hours of much use, and the one made of vulcanite, such as I have employed for years after a lumbar colotomy, answers admirably; it is about from $2\frac{1}{2}$ to 3 inches long and about $\frac{3}{4}$ inch wide. It should be kept in position by means of a T bandage and the buttocks should be drawn close together also by a bandage.

On Villous Growths and Polypi of the Rectum.

Polypus of the rectum in its different varieties is not so rare a disease as writers would lead us to believe. In the adult it is so, comparatively; but in the child it is *the principal cause of*

Fig. 18.



Vascular polypus of the rectum in a child.

hæmorrhage from the bowel, and from this fact cases of polypus have been doubtless wrongly put down as those of hæmorrhoids, which as an affection of child-life is almost unknown. In children and young adults polypi are chiefly of the mucous variety. In adults they are more fibrous and the graver kinds assume the form of a villous growth, the villi being composed of coarser or finer sessile dendriform structure, to which a distinct section of this paper will be bestowed. The mucous growths are generally found in children under 10 years of age, and in male more commonly than in female subjects, since out of 35 consecutive cases 29 were in males, and 27 were in children under 10 years

of age, and eight in adults (Fig. 18). These growths vary in size from that of a pea to that of a large cherry; they grow from the

Fig. 19.

Fissure of the anus with polypus above the fissure.

submucous tissue, and are covered by mucous membrane. When far beyond the reach of the sphincter and when small they prob-

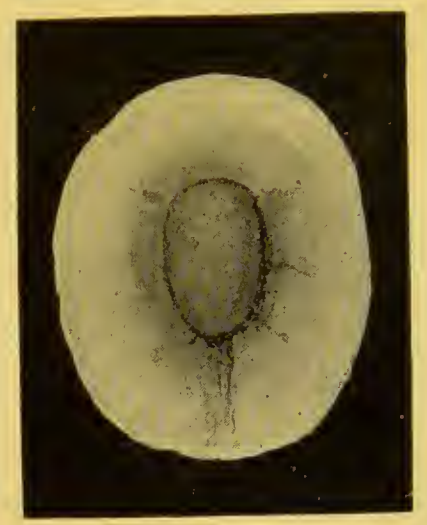
Fig. 20.

Fissure of the anus with polypus opposite the fissure.

ably do not cause any inconvenience, though when large they may give rise to straining or ulceration of the bowel, prolapsus

recti, and even intussusception. In some cases a polypus is associated with ulceration of the rectum, the ulcer at one time existing below the polypus, in another on the wall of the bowel opposite its body. In Fig. 19 and Fig. 20 these conditions are illustrated. One of the worst examples of prolapsus recti I have ever been called upon to treat was due to the presence of a fibrous polypus situated some inches up the bowel of a man 50 years of age who had suffered from it for 27 years (Case 2). He was cured by the removal of the growth. When these growths are attached to the bowel near the sphincter, local irritation and hæmorrhage are produced, the growth appearing often at the

Fig. 21.



Fibrous polypus of the rectum appearing at the anus.

anus as a pink or red cherry (Fig. 21 and Fig. 22). Blood sometimes flows from the anus only during defecation, at other times quite independently of such an action. When the polypus is low down there is usually with the blood a free discharge of mucus.

Whenever a child is brought to a surgeon with these symptoms a local examination should be made, and to do this efficiently the surgeon should sweep his finger introduced into the rectum completely round the walls of the bowel. By so doing the polypus will be dragged from its attachment and its pedicle made tense. Sometimes several polypi exist together. I have on one occasion removed three. They are made up of fibro-cellular tissue, being more or less fibrous, according to the age of the patient; in the

adult the fibrous element predominates. In exceptional cases the fibrous polypi of adults are multiple. I shall later quote two examples of this kind, in one of which (Case 3) the rectum eventually even for a foot or more upwards became covered with sessile fibrous polypi varying from the size of a pea to that of a large almond, and in the other (Case 4) these sessile fibrous polypi followed the removal of a large villous growth some months previously. When a polypus has been discovered its removal is the only correct practice. In children, when I detect one with the finger, I generally manage to hook it down, and in so doing often break it off from its attachment to the bowel. I have never seen any bleeding

Fig. 22.

Fibrous polypus of the rectum in an adult.

follow this measure. On several occasions when I have brought the growth external to the sphincter the action of the muscle has broken it away, and in this manner many cases of polypi are doubtless naturally cured. When they do not break off, a ligature may be applied to the pedicle and the growth cut off beyond the knot. In adults the ligature should always be employed. On the removal of the disease the symptoms disappear, but when they continue a second polypus will generally be found. In rare examples as already indicated multiple polypi are found. The following cases will illustrate the subject :—

Case 1. *Great prolapse of the rectum due to fibrous polypus; operation; recovery.*—A woman, aged 33 years, came to me in August, 1874, for a

serious prolapse of the rectum, associated with severe straining and loss of blood. The bowel had been down for many months, and it protruded for at least 6 inches, but for some nine months before it had come down to stay it had occasionally protruded when the bowels had acted, but at that time there was but little bleeding. On making an examination I detected about 3 inches up the prolapsed bowel a sessile fibrous polypus of about the size of a small walnut, which I subsequently pulled down into view and removed by clamp and cautery, after having dilated the external sphincter. The prolapsed bowel was readily returned, but not so readily maintained *in situ*. This position was secured, however, by the introduction of my colotomy vulcanite plug and its retention for a few days, when a good convalescence followed.

Case 2. *Prolapsus recti of twenty-seven years' standing due to the presence of a fibrous polypus; removal of the polypus; recovery.*—(The following notes were taken by Mr. E. W. Deane.) A man, aged 47 years, was admitted into Guy's Hospital under my care on March 1st, 1875. His family history was good excepting that his father and sister were subject to what were called "piles." He himself had tolerably good health, although when 20 years old he first noticed a pain when his bowels acted. Some 17 years after this—that is, 10 years before his admission—the pain had considerably increased, and he noticed that there was something protruding from his anus when he had a motion which he used to put back. The protrusion occurred not only when he passed a motion, but subsequently when he walked. He consulted surgeons, who treated him with lotions and medicines. His complaint was supposed to be "piles," and he was advised to obtain admission to Guy's Hospital, where it was found that he had a prolapsed rectum. The bowel protruded for about 3 inches, and the rectum was very loose. Upon examination a fibrous polypus was detected high up the bowel. This was seized by a pair of long forceps and brought into view, when a double-threaded needle was passed through its base, which was tied in halves, and the polypus removed with a pair of scissors. A morphia suppository was placed in the rectum and a subcutaneous injection was given, after which the patient passed a good night. His progress towards recovery was uninterrupted.

Case 3. *Sessile polypus high up the bowel causing for six years tenesmus with bowel irritation; removal of the polypus with relief for one year; return of growths in numbers; lumbar colotomy with marked benefit; death six years later from pneumonia.*—In 1876 I was consulted by a man, aged 44 years, who was said to have had dysentery some years previously, for great bowel irritation and tenesmus associated with the passage of a quantity of rice-water mucoid fluid. These attacks would come on every three or four hours during the day, but were less frequent at night. They had gradually been coming for five or six years. Suspecting the presence of a polypus I consequently investigated the case with the patient anæsthetised, when after a careful examination my diagnosis was confirmed and I was able to draw a sessile fibrous outgrowth from its high position in the rectum down into the lower part. This I subsequently cut off, after having applied a ligature to its base. The growth was clearly fibrous and of about the size of an almond. The operation gave much relief, but in the course of months the symptoms returned with steadily increasing intensity, and at the end of the year I found the lower bowel as far as I

could reach studded everywhere with the same fibrous outgrowths as I had before removed. Under these circumstances I performed left lumbar colotomy with marked immediate, and indeed with permanent, success, for although the lower portion of the bowel, for the six years of life which were subsequently enjoyed, discharged upwards and downwards the same rice-water mucoid fluid there was no pain or even tenesmus, and had the patient not been attacked with an acute pneumonia there was nothing in the condition of his bowel to have shortened his life. It is much to be regretted that I am unable to give any account of the pathological condition of this patient's bowel, but he died away from London, and a *post-mortem* examination was not obtained.

Case 4. *Removal of a villous rectal polypus followed by the growth of diffused multiple fibrous polypi.*—In April, 1872, I was consulted by a man, aged 45 years, for the frequent discharge from the bowels, with and without motion, of watery mucus, associated with much griping pain and tenesmus. These symptoms had existed for a year, and had been gradually becoming worse. At times the rectal discharge was blood-stained when not blood. On examination I found high up the rectum a sessile villous growth which in May of the same year I was able to get hold of with fenestrated forceps and to bring down sufficiently low to allow me to place a ligature round its base in halves and to cut it off. Its base was of about the size of a shilling. Immediate relief followed this operation, and the patient for some five years thought he was well, when the symptoms returned, although with much less severity. I then examined him again and found another sessile polypus, but of a fibrous form, not villous in character, of about the size of an almond, apparently growing near the spot whence the first one had been taken away. This also I removed in 1878. For a time the patient was again comfortable, and it may have been a year or more before the old symptoms began to show themselves, but it was not till 1886 that I again saw him. I then found on making a rectal examination that the bowel was, as far as I could reach, absolutely studded all over its surface with sessile fibrous polypoid growths, similar to the second one I had removed eight years previously. As these could not be taken away, and it was a question how far they involved the bowel, I performed a lumbar colotomy in January, 1886. I was pleased to find that the intestine at the seat of operation was quite healthy in both directions as far as could be reached. Rapid recovery followed this measure, and much comfort was given, but as time passed the rectal trouble increased so far as discharge was concerned, and some of this came upwards and escaped through the lumbar anus, and was at times mixed with much blood. Later, the lower extremity of the bowel occasionally even worked its way out of the lumbar wound and presented the appearance of an inverted horn or cornucopia with its mucous surface covered with the fibrous sessile outgrowths which I have described. The reduction of this was readily effected, but at times it would reappear. The question of further operative measures was discussed, for I thought it quite feasible to have removed the seat of disease now a healthy lumbar anal opening had been established and there was no evidence of any disease of the colon above, but neither the patient nor his friends would take this proposal into consideration, so the patient returned to his country home and made the best of matters until December, 1889, when he died, aged 62 years, from bronchitis and heart failure, 17 years after the removal of the

villous polypus to which I have alluded. The connection between the villous rectal growth and the fibrous sessile polypus is well illustrated in this case. I have in no other found them to have been associated.

Villous Growths of the Rectum.

Villous or papillary growths are met with in the rectum, as they are in other parts of the large intestine, more frequently than is generally believed. When high up these growths may give rise to intussusception; when low down, to prolapse of the rectum. In Fig. 23 the appearance of such a growth below the anus is

Fig. 23.

Villous tumour of the rectum in a female, aged 64 years.

well illustrated. In Figs. 24 and 25 its structure is clearly displayed. In 1894 I reported two cases* of intussusception of the large intestine, due to the presence of a villous growth, which I successfully reduced by the introduction of my hand into the rectum after the removal of the growth. One (Case 5) was in a woman, 84 years of age; the second (Case 6) was also in a woman, aged 50 years. Both patients made excellent recoveries,

* 'Transactions of the Royal Medical and Chirurgical Society of London,' 1894.

and neither had any further bowel trouble. The details of the cases are as follows:—

Case 5. *Villous growth of the rectum associated with intussusception; removal of growth; recovery.*—On October 22nd, 1886, I was asked to see Mrs. R., a healthy old lady, 84 years of age, for intussusception; and I now quote the history of the case from Dr. Mackern's report. The patient was first seen on October 20th. She was then suffering from dyspeptic symptoms, accompanied by intermittent abdominal pain of a griping character. The bowels had acted, but not in a satisfactory manner. Carminatives and directions as to diet were given.

October 21st.—Pain still present, and more severe. Bowels had not acted. A feeling of nausea existed. A teaspoonful of castor oil was ordered.

22nd.—Sickness followed all food. Bowels still obstinate. A careful examination of the abdomen was made, when the left side of the abdomen was found to be full, and through the thin abdominal parietes coils of intestine were seen working and twisting about. There was no hernia.

A rectal examination at once proved that there was an invagination into the lower bowel of some part of the tube higher up. Mr. Bryant was at once called in, and his examination brought to light the fact that there was an intussusception into the rectum, and that this was due to the presence of a large papillomatous growth attached to the wall of the orifice of the inner tube—the intussusceptum.

An operation was decided upon on the morning of the following day.

23rd.—Ether was given. The anus was forcibly dilated. The growth and bowel to which it was attached were pulled down below the sphincter and held. The growth was then ligatured at its base in two parts and cut off, and the bowel returned. This was effected by the introduction of the right hand through the dilated anus into the rectum, well above the wrist, when the bowel suddenly rushed away from the hand.

The next morning the patient was comfortable, having lost all her pain and sickness. On the fourth day after the operation an enema was given without any good result. On the fifth day the bowels acted, and from this time the patient made steady progress to recovery, and she never had any trouble with the bowels afterwards. She regained more than her previous strength and took an active interest in everything, being both mentally and bodily surprisingly robust for her age. In October, 1887, or one year after the operation, she was taken ill at St. Leonards, and died on October 31st from paralysis of the left side of her body, in her 86th year.

Case 6. *Villous growth of rectum; removal of growth; recovery.*—On August 7th, 1893, I was asked by Dr. Gilbert Richardson to see Miss R., æt. 50, who was suffering from obstruction of the bowels of 20 days' duration, associated with colicky abdominal pain and tenesmus, with the discharge of mucus from the bowel.

From the report of the case kindly supplied to me by Dr. Richardson, it appeared "that the patient had always been a weakly subject, and had suffered for many years from functional liver trouble and attacks of gastro-enteric catarrh. The early attacks usually lasted about four or five weeks, and were followed by a period of good health of five or six months' duration, after which a renewal of the symptoms took place. As years passed, however, the attacks became more frequent and more

severe. During the attacks mucus was often passed with the motions, and at times this was blood-stained." "During June, 1893," wrote Dr. Richardson, "the patient had been coming to me at weekly intervals, suffering from a condition apparently similar to the usual illnesses, except that more mucus was passed from the bowel, and the treatment employed was attended by less benefit than had formerly been the case." On July 24th, the patient being too ill to leave her home, Dr. Richardson was sent for, when he found her in bed with a temperature of 100°, suffering from a good deal of colicky abdominal pain, restlessness, nausea, and constipation of a week's standing, and, as the patient was thin, a hard mass, supposed to be a collection of faeces in the ascending and transverse colon, was made out to be present. Enemata of oil were ordered, with pills of conium and belladonna, and directions given to report progress to Dr. Richardson. Ten days later, as all the symptoms had steadily become worse, and the means employed had failed to give relief, he was again sent for, when, on making a rectal examination, he discovered the presence of an intussusception just within the reach of his finger, but which, after the lapse of two or three days, had descended to the anus.

I saw the patient at this time (August 7th) with Dr. Richardson, and having obtained the history of the case as just recorded, proceeded to examine her. I found, as I expected, a pronounced intussusception filling the rectum, and attached to about half of the orifice of the invaginated bowel a large papillomatous growth. The abdomen was very lumpy, but no distinct tumour could be felt.

The next day, August 8th, the patient being anæsthetised, I proceeded to remove the tumour, and with the kind help of Dr. Richardson completed the operation, including the reduction of the intussusception, in a very satisfactory way.

The operation.—I first of all forcibly with my thumbs dilated the anus to its fullest extent, and then with ring forceps drew down externally the invaginated bowel with the growth attached to it. I next isolated the short peduncle of the growth, and with a needle armed with a thick silk ligature perforated its base so as to enable me to keep it *in situ*, and then, having ligatured the base of the growth in three sections, cut it off. The bowel was subsequently carefully examined, so that no other growths should be left, papillomata being often multiple.

The reduction of the intussusception was then proceeded with as follows :—I first well anointed my right hand and forearm with carbolised vaseline, and with the patient on her left side took the exposed end of the intussusceptum—from which I had removed the growth—between my fingers and thumb, and returned it within the anus, at the same time by a steady and not very forcible screwing movement of my hand followed the bowel upwards until my hand and forearm beyond its middle had disappeared into the rectum. At first I simply mechanically pushed the intussusceptum upwards, but when I had reached the distance described, the bowel suddenly escaped from my fingers and passed out of reach. I concluded by these signs that the intussusception had been reduced, and so withdrew my hand. In this view I was not disappointed, for after the operation everything went on favourably, all pain ceased, the bowels slowly emptied themselves of their impacted contents, and no complaint was subsequently made of incontinence of faeces or more than a temporary anal soreness. Indeed, the patient speedily convalesced, and is now in good health.

The two cases which have just been related are worthy of record, not only on account of their comparative rarity, but from the practical lessons which are to be learnt from their consideration.

I would, however, like to point out that prolapse of the rectum, and invagination with intussusception of the large or small intestine, are but different degrees of the same condition; and that both are brought about by the same causes, namely, local irritation. The surgeon is familiar with prolapse of the rectum in cases of piles and rectal polypi, as well as in those of ulceration of the rectum and of local irritation by worms; and he meets with the same condition in the rarer but not less marked cases of papilloma of the rectum. He recognises also a certain degree of invagination of the bowel in cases of annular stricture of the rectum, cancerous or otherwise. Here the orifice of the strictured bowel feels to the finger introduced into the rectum either like the exaggerated and patulous mouth of an elongated neck of the uterus, or like a more complete example of intussusception. In the former class of cases the bowel prolapses through the anus. In the latter the upper part of the bowel prolapses as an invagination into the lumen of the canal below.

It would be well for the surgeon to recognise with equal confidence the view that local irritation of any kind, either the result of the presence of a new growth—simple or cancerous, of an inverted diverticulum, or of some other local cause of a more temporary character, when applied for a sufficient length of time to any part of the lumen of the intestinal tract, is prone to be followed by prolapse, invagination, or intussusception; and that these conditions are most liable to occur when the local source of irritation is situated either above and within a few inches of the ileo-cæcal valve—where there is a narrowing of the bowel followed by an expansion, or within a few inches of the anus, at which a like narrowing of the bowel exists.

In support of this view I would adduce the well-recognised fact that ileo-cæcal intussusceptions are the most common in young life, when temporary local sources of irritation are most common; and that in the middle-aged and old people, when intussusception and severe examples of prolapse of the rectum occur, some papillomatous growth, if looked for, will very frequently be found; and lastly, that in our museums excellent examples of intussusception

due to the presence of papillomata, polypi, and cancerous or other growths are to be met with.

I may add that it was from a full recognition of this view that I was led in both the cases I have brought before you to search for the cause of the intussusception and thus to effect a complete cure. For I conclude that every one present will accept the opinion that it was from the presence of the papilloma in the bowel, and the irritation it produced, that the intussusception was brought about; and that the intussusception was really due to nature's efforts to get rid of the irritating offending growth. To illustrate this matter further, I may refer to some specimens from the Guy's Hospital Museum.

The first (1819[95]) is one of intussusception of the *small intestine* about 3 inches above the cæcum, due to the presence of polypus the size of a chestnut with a broad pedicle. It was taken from the body of a woman, aged 42, who died after an illness of 10 months under the care of the late Dr. Moxon, and who had suffered from gnawing pains at the umbilicus for nine months previously, associated with diarrhœa, vomiting, and abdominal distension.

The second (1849[18]) shows a *jejunal intussusception* with polypoid growth at the apex of the intussusceptum, taken from a young woman, aged 19, a patient of Dr. Goodhart, who suffered from periodical attacks of vomiting and abdominal pain for nearly two years before her death, and in whom a kidney-shaped tumour was felt in the lower part of her abdomen, which towards the end of her illness was observed to undergo slow rhythmic alterations, being alternately hard and well defined and soft and ill defined.

The third (1819[45]) is one of an *inverted diverticulum* of the ileum causing intussusception, taken from James C., aged 22, who was admitted under Dr. Fagge for constipation and vomiting of five days' duration. He was operated upon by laparotomy and the intussusception was reduced, but he died a few hours after the operation.

Three are examples of cancer of the colon associated with intussusception, viz.:—

Specimen 1849[17], which was taken from a woman, aged 50, who suffered for months before death from chronic intestinal disturbance and a lump in her right flank, and passed also a large shred of sloughing tissue. The intussusceptum, which was

of the colon, was enormously thickened, and at its apex there is a sloughing mass of growth attached by a slender pedicle.

Specimen 1875^{5}, which is a portion of colon in a condition of invagination. The intussusception is about 4 inches in length. The wall of the intestine at the returning angle is greatly thickened, and the mucous membrane of the entering layer is partially destroyed by ulceration. Histologically the wall of the gut is infiltrated by a growth of cylindrical-celled carcinoma.

Specimen 1887^{75}, which is one of adenoid cancer of the rectum causing intussusception, taken from a man, aged 44.

In Cases 5 and 6 the cause of the intussusception was the presence of a papilloma of large size; in both the papilloma had a broad base, and involved only a segment of the circle of the intestinal lumen; and in both it was quite certain that the disease was situated high up the bowel, that is, at a far distance from the rectum, for in Case 5, when the intussusception was reduced after the removal of its cause, I had to introduce my hand well beyond the wrist to carry out my object, and the bowel then sprang out of my fingers with a rush, like that of the intestine in a case of reduction of strangulated hernia by the taxis; and in Case 6 I had to insert my hand and forearm nearly up to the elbow before the intussusception of the involved bowel escaped upwards from the hollow of my fingers in which it rested.

It seems also from the two cases, and from the preparations I have referred to, that a growth which involves only a segment of the circle of the intestinal lumen is more likely to be associated with a complete intussusception than an annular stricture, as it is certain that these papillomata when they attack the rectum are attended with far more straining, tenesmus, the discharge of serous fluid, and prolapse than any other growth, whether cancerous or otherwise.

There is no need to say much as to the treatment of these cases, for it was such as the judgment of any good surgeon would support when the diagnosis of the case had been determined upon; but surely its success is suggestive of a lesson we might well take to heart, and should lead us to apply the means which in these two cases proved so successful to future examples of intussusception in adult females which have made their way into the rectum, whether due to the presence of a growth or to some unknown cause.

In many cases it is more than probable that success would not follow, but in some it surely would be achieved; in the only two examples in which I have employed it, or I think I may say in which it has been employed, the result has been all that could be wished.

I may add that I found little difficulty in introducing my hand into the rectum after I had forcibly dilated the anus. A steady half-screwing movement, alternating with moderate pressure, effected the desired purpose, and enabled me to pass the anal orifice of the bowel as well as the narrowing of the bowel at the brim of the pelvis, and these two points being passed, all difficulty vanished.

I have never succeeded in passing my hand into the rectum of a male patient, but have never failed in the case of the female adults upon whom I have made the attempt—about a dozen in all—and my hand when closed for introduction measures over the knuckles $9\frac{1}{4}$ inches.

I may add that in neither of these cases, nor in more than one of the others in which I have introduced my hand into the rectum, has any very prolonged want of control of the anal sphincter been complained of.

I propose now to extend these remarks a little further, and to demonstrate their truth by the quotation of seven additional examples of villous rectal growths associated with marked tenesmus and the discharge of much mucoid fluid, and, in many, of blood. These seven cases, with the three already reported, make a total of 10 cases of villous rectal growths, seven of which occurred in women and three in men. I have had three or four other cases of the same kind, but have not sufficient notes of them to record. The specimen removed from one of these may, however, be seen at Guy's Hospital Museum, No. 1,013. Others, I regret to say, for museum reasons have been thrown away. The growths removed in Cases 4 and 5 are in the museum of the Royal College of Surgeons of England.

Case 7. *Prolapse of the rectum associated with much hæmorrhage due to a villous rectal growth; operation and recovery.*—A woman, aged 43 years, came under my care at Guy's Hospital in June, 1867, for a severe prolapse of the rectum associated with loss of blood after every motion, from which she had suffered for 20 years, the straining at times being most distressing. When I saw her the bowel was down for about 9 inches; blood was then passing with her motions, and the pain was

great. I made a careful examination, but failed to find anything. I reduced the prolapsus and prescribed rest. On my second visit, with the bowel only down a very little, I examined her again, and with my finger could just touch a new growth. With a pair of long fenestrated forceps I took hold of it and brought it down, finding a splendid specimen of the coarse villous polypus. I put a ligature round its base at once and cut off the growth. No single unfavourable symptom subsequently

FIG. 24.

Villous polypus of the rectum.

FIG. 25.

The drawing was taken from a vertical section of the villous growth illustrated above, and showed vascular simple and compound villi covered with columnar epithelium, large vessels in the base on which the villi rested, and sections of the follicles of Lieberkühn. The section represents half the thickness of a lobule of the polypus by a 1½ inch power.

appeared; all her former troubles at once vanished, and a complete recovery ensued. Three years later this woman was still well. The growth is illustrated in Fig. 24, with its microscopical appearance, as shown in the late Dr. Moxon's drawing (Fig. 25).

CASE 8. *Papilloma of the rectum with prolapse of the bowel; operation; recovery.*—In 1876 I was consulted by a woman, aged 52 years, for great

prolapse of the rectum, associated with the discharge of much blood-stained mucus, and at times of blood accompanied with straining. The bowel had been down for some months, but for at least a year before it had come down when straining at stool, and at these times there was a free discharge of watery fluid. An examination revealed the presence of a sessile villous polypus high up the rectum, which was drawn down by means of forceps into view, ligatured, and removed, a rapid recovery taking place.

Case 9. *Villous growth of the rectum; prolapse of the rectum; operation; recovery.*—In 1881 I was consulted by a woman, aged 56 years, for prolapse of the rectum of three months' standing, associated with tenesmus and the frequent discharge of blood-stained watery mucus. For about six months previously she had noticed the same mucous discharge, which was accompanied with diarrhœa. On examination a sessile papillomatous growth was found on the dorsal surface of the rectum, about 3 inches up, with a base 1 inch in diameter. This was drawn down and ligatured in halves at the base and cut off. A rapid and complete recovery followed.

Case 10. *Villous growth of the rectum of 20 years' standing; loss of much blood; operation and recovery.*—In June, 1881, I was consulted by a man, aged 35 years, who when only 15 years of age passed blood at his stools accompanied by much straining. Since then, at intervals varying from three days to a month, the symptoms returned. He would for a week or two weeks together pass blood with every motion, and the blood would generally flow from the bowel for 10 or 15 minutes after defecation, but sometimes he would pass no blood for three days. At these attacks there would be great straining, but no prolapse of the anus. Much mucus would, however, at all times be passed with the motions. An examination made with the patient anæsthetised during one of these attacks revealed the presence of a papilloma attached to the orifice of an intussuscepted bowel, high up the rectum. This I pulled down by means of a long pair of fenestrated forceps and, having ligatured its base in halves, I removed it. The growth covered the area of a florin. Everything went on well subsequently, and a rapid and permanent recovery ensued.

Case 11. *Villous growths of the rectum; operation; cure.*—In April, 1883, I was consulted by a man, aged 56 years, for the discharge of much mucoid fluid from the rectum, accompanied at times by straining and occasional prolapse of the rectum. These symptoms had been steadily becoming worse for six or more months, but for the last month the constant bearing-down pain and discharge had induced him to seek advice. On examination the external anal parts looked healthy, but internally about 3 inches up the rectum and on its dorsal aspect a villous growth was found. This was then dragged down by means of forceps and removed, after its base, which was of about the size of a shilling, had been ligatured in halves. A rapid convalescence ensued.

Case 12. *Villous growth of the rectum; operation; cure.*—A woman, aged 56 years, the mother of three children, consulted me in August, 1889, for severe tenesmus and the passage of much mucus from the bowels, which for the last month was blood-stained. These symptoms

had existed for more than two years and had been gradually becoming worse. On examination under an anæsthetic, a hard, papillomatous growth was detected high up the bowel, which was partly invaginated, and after some trouble this was seized and brought down, where it could be ligatured at its base and removed. The base was of about the size of a florin. A good recovery ensued, and five years later this patient was quite well.

Case 13. *Villous growth in the rectum; removal; recovery.*—In October, 1890, I saw, in consultation with Mr. G. Eastes, a woman, aged 69 years, who for some months when at stool had suffered from abdominal straining and the passage of much mucus, which for the last month had been mixed with blood. During the last month something was forced through the sphincter of the anus so as to protrude externally, but this was reduced with ease by the application of external pressure. On examination of the rectum I detected a large cauliflower villous growth attached to the anterior wall of the rectum, about 3 inches up, which I was able by means of forceps to draw down outside the anus and to remove after having ligatured its base in halves; a rapid recovery followed. This patient lived in comfort for six years after the operation, and died on June 12th, 1896, from pernicious anæmia, at the age of 75 years.

From a careful consideration of these cases of villous rectal growths the following conclusions seem to be reasonable:—

That a villous growth of the large intestine is by no means uncommon, and particularly in women.

That when an adult is liable to attacks of abdominal straining, associated with the passage from the bowel of rice-watery mucoid fluid or thick mucus in any quantity, the suspicion of the presence of a villous growth should be excited.

When the straining is persistent, or relieved by only brief intervals, and blood becomes mixed with the mucous discharge, the probabilities of the presence of a villous growth are much strengthened.

When prolapse of the bowel becomes constant, and this is attended with the discharge of bloody mucus, or blood alone, careful search for a villous growth should be made.

The diagnosis becomes clear only when the growth appears with the prolapsed bowel at the anus, or can be detected with the finger. In all cases of intussusception in adults, the question of a villous or polypoid growth being the cause should be entertained.

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